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Circular Letter

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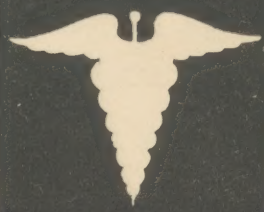
19 July 1954

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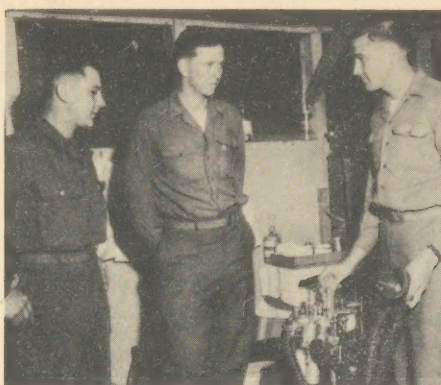
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APO 500

SECOND DIVISION MEDICAL NCO'S LEARN EVERY ASPECT OF HOSPITAL PROCEDURES AT 8063RD MASH AND 121ST EVAC



... they carefully unload an ambulance load of battle casualties.



... learn the use of the Heidelbrink portable anesthesia machine.



while nurses instruct in the types and uses of surgical instruments



Capt Eleanor Faulk gives the NCO's instruction in use of anesthesia



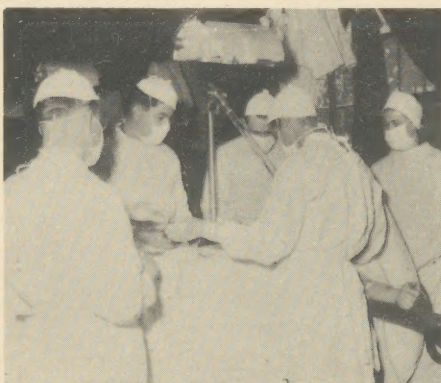
and Lt Peacock, 8063d MASH, explains a method of donning surgeon's gloves



... the sergeants learn how to apply plaster casts at the 121st Evac.



... where with nurses they fold hospital linens for autoclaving



... and Capt Seven illustrates OR procedures with help of mock patient.



... and finally the NCO's help prepare a patient for evacuation from the MASH

on the cover

An Eighth Army ambulance attempts to cross the road flooded by the rampaging Imjin river somewhere in Korea. (All photos by US Army Signal Corps)

THE SURGEON'S

Circular
Letter

Volume VII - Number 8

AUGUST 1952

Headquarters
Far East Command
Medical Section
APO 500

ADMINISTRATIVE

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MSC OBSERVES FIFTH ANNIVERSARY

Monday, 4 August 1952, marked the fifth anniversary of the Medical Service Corps --in name only, that is. Actually an activity in existence for over 30 years under different titles, the name was changed from "Medical Administrative Corps" on 4 August 1947 by Department of the Army directive.

During World War I the Army Medical Service expanded to the point where, before the end of 1918, there were 100,000 more personnel than in the entire Regular Army just prior to the war. Foreseeing the many difficulties that would arise from burdening the Army doctors with additional duties incumbent in so large an establishment, top level planners in the Surgeon General's office organized the Sanitary Corps, embryo of the present Medical Service Corps. The members of this corps were selected from highly trained and educated civilians with technical knowledge that made them valuable in laboratories and other auxiliary medical tasks. Charged with the responsibility of furnishing the necessary technical assistance to Medical Corps officers, many routine, though professional, duties were shifted from the shoulders of the overworked doctor.

Shortly after World War I, officers of the Sanitary Corps were commissioned in the Medical Administrative Corps. Within the next few years, more and more duties previously assumed by doctors became the added responsibility of MSC officers. Today, the Medical Service Corps officer assists in the administrative and technical affairs of the Army Medical Service in such capacities as optometrists, chemists, food and nutrition experts, hospital architects, psychologists, sanitary engineers, pharmacists, bacteriologists and other technical sciences allied to the functions of the medical service. In addition, they are medical supply officers, registrars, detachment commanders, adjutants, personnel officers and instructors. They also serve as battalion surgeons' assistants, administrative officers and ambulance and litter bearer platoon leaders in tactical medical units.

Working with Army officers in all branches and at all levels, the Medical Service Corps officer is lending valuable assistance to the task of maintaining a high standard of medical service in the United States Army.

SURGEON GENERAL REQUESTS CONTINUANCE SPECIAL PAY FOR MC-DC OFFICERS

Major General George E. Armstrong, MC, The Surgeon General, United States Army, recently appeared before a subcommittee of the Committee on Armed Services, United States Senate, to outline his views in relation to the special pay of \$100.00 per month now being received by doctors and dentists. General Armstrong's statement is considered of sufficient importance to warrant verbatim publication for the information of all officers concerned.

"Mr. Chairman and members of the Committee:

"I am Major General George E. Armstrong. In my capacity as Surgeon General of the Army, I appear before you today on behalf of the Department of Defense, as well as the individual Military Departments.

"With your permission, I have a brief statement concerning continuance of special pay for medical and dental officers of the Armed Services which I should like to present to the Committee at this time.

"The Medical Services following World War II found themselves unable to maintain on voluntary basis medical and dental corps competent to furnish even a minimal standard of medical attendance to our Armed Forces. Procurement was at a standstill and serious depletion by resignations was being experienced. In great part this was due to the wide disparity between the income of physicians and dentists in civilian life as compared with those in the military service. In the Army's integration programs after the war, for example, the needs of all of the other branches of the Army except the Medical Ser-

vice were met on a voluntary basis. The other branches averaged five applicants for every available commission. But for the Medical and Dental Corps there was but one applicant for every three vacancies. The experience of the Navy was quite similar.

"To meet this critical situation, the Congress, in 1947, explored ways and means of making the military service more attractive to these professional peoples. During the course of the hearings it became evident that, entirely apart from the question of disparity of earnings between medical and dental officers, on the one hand, and civilian physicians and dentists, on the other, a basic inequity in the pay structure of the Armed Forces existed, wherein medical and dental officers were at a considerable disadvantage in terms of life earnings in comparison with other officers. If this fact is kept in mind, it is clear that special pay for medical and dental officers is not a 'bonus'.

"An individual pursuing a four-year technical or scientific course leading to a baccalaureate degree in an accredited university, meets upon graduation the educational requirements for appointment as second lieutenant or ensign in the Armed Forces. In contrast, a medical or dental student must finance a total college education of up to eight years. In addition, all medical and some dental graduates spend a year in intern training, usually receiving only a token compensation. Their former classmates at college, in the meantime, have been receiving full pay and allowances as second, and later as first, lieutenants (j.g.). When the physician or dentist finally meets the requirements for a commission in the Medical or Dental Corps of the several Services, his former classmates have a four-to-five year lead. Thirty years after they started their respective careers, the other categories of officers are some \$40,000 ahead of the medical or dental officer

"The justice of this special pay was determined by Congress in 1947. Both the monthly amount and the basic justification of the Bill were in terms of equalizing pay within the Services. All arguments advanced in the interest of the passage of the Bill at that time have equal, if not increased, validity today. What is the logic after September 1, 1952, that would justify denying to the physician or dentist who enters active military service after that date the same consideration of equitable adjustment of cumulative compensation over a 30-year period of service? What is the logic that would justify denying recognition to our future medical and dental officers of the self-borne costs of securing the professional education and training demanded of them before they are eligible for appointment in the Medical or Dental Corps of the Army, Navy, or Air Force?

"Following the passage of Public Law 365 in 1947, which provided for special pay for medical and dental officers, losses due to resignation sharply declined and procurement for the Regular Medical and Dental Corps in the several Services showed a prompt and definite improvement.

"It is true that, by means of such compulsory devices as Public Law 779 (the so called 'Doctor Draft Act') and the Universal Military Training and Service Act of 1951, the numerical requirements for medical and dental officers for the Armed Services can be met and maintained. It must be remembered, however, that personnel expected to be procured by operation of the Universal Military Training and

Service Act will be relatively young and inexperienced. They will not possess the qualifications required for assignment to command and staff-type positions, nor to duties requiring specialists' qualifications. The operation of efficient medical services within the Armed Forces requires strong Regular Corps for the more responsible positions. These positions constitute roughly 50% of the overall requirement for medical and dental officers. The only source from which these officers may be obtained is from the ranks of the Regular Corps. Broad experience in military medical practice determines the usefulness of these officers in the military service, and short-term or compulsory service cannot provide such experienced officers. This group of professionals is currently at the absolute minimum for efficient operation. There exists today a shortage of 2311 career medical officers and 291 career dental officers in the authorized strength of the Armed Forces. Even the current numbers of career dental officers would have been impossible to obtain without this special pay.

"Failure to extend the provision for special pay will also result in a gross inequity in the treatment to be accorded officers brought to active duty under the operation of Public Law 779, 81st Congress. It should be noted that, prior to enactment of Public Law 779, only 'volunteers' were eligible by law for the special pay. The Congress, however, in enacting Public Law 779, specifically provided therein, on its own initiative, that members of the Reserve Components, medical and dental called or ordered to active duty with or without their consent would, if otherwise qualified, be eligible for the special pay. A result of non-extension of the present time limitation beyond 31 August of this year will be that all Reserve physicians and dentists ordered to active duty prior to 31 August of this year will receive this special pay during their service. Their fellow physicians and dentists, however, commissioned under operation of the same law, but ordered to active duty subsequent to 31 August of this year, will not receive it. The inequity of such a situation requires no discussion.

"The burden of responsibility that will fall upon the Regular Medical and Dental Corps of the Armed Services will become increasingly heavy within the next two years. There are today in the service many mature Reserve and National Guard medical and dental officers who were involuntarily called to duty during the current emergency, and who are holding responsible positions. It can be expected that these officers will return to their civilian practices within the next few months. Furthermore, as I have indicated, the medical and dental officers furnished by Selective Service will be relatively young and inexperienced. As a result of these two factors, the Regular Medical and Dental Corps will have to satisfy practically all of the responsible positions in the Service concerned. To satisfactorily meet their responsibilities, the Regular Corps must be brought up to their authorized strength in the shortest possible time. During the effective periods of Public Law 779 and the Universal Military Training and Service Act, a fertile source for potential procurement of Regular Medical and Dental officers exists. The maintenance of present incentive of special pay is essential if maximum benefit is to be derived by the Armed Forces during this period. It will help us by affording continued encouragement to the best of these younger physicians and dentists to seek a career in the Armed Forces.



"I understand that it has even been proposed to repeal Section 203(a) of the Career Compensation Act, the effect of which would be to take away special pay from these officers already entitled thereto. A majority of the Regular Medical and Dental Corps has been procured since the passage of the special pay act, Public Law 365 in 1947. I do not believe or contend that the sole factor in their decision to enter the Regular Service as a Medical or Dental Corps officer was the prospect of receiving during their service this extra monthly sum. I cannot doubt, however, that as any man must, they considered the matter of total compensation. They left, or did not seek, the civilian opportunities which most, if not every one of them, could reasonably expect to enjoy, and entered the military service. To withdraw from them at this time the equalizing compensation which had been promised to them to encourage their assumption of military status, would be a most unjust treatment - a treatment which in the eyes of the ordinary citizen would appear to be a promise broken, whatever the legal validity of such belief. To return to the unfair pay scale and repudiate the correction previously made and to abrogate the promise, if not the contract, made with those now in the Service, would certainly end voluntary officer procurement. Furthermore, consideration should be given to the fact that presently the need for these career officers is such that voluntary retirements, and even resignations, have been forbidden. The inequity of reducing the pay of such a 'captive group' is so patent that I am sure the Congress would never countenance such an injustice.

"The physicians and dentists who enter the Regular Service on and after September 1, 1952, to keep up our ranks will be in precisely the same situation as regards the length and additional cost of their education as were their fellow medical and dental officers who entered the Service before them. They, too, will be 4 to 5 years behind their fellow officers of the other arms and services in cumulative earnings. It is difficult, therefore, to understand the basis on which the officers entering the Medical and Dental Corps of the Army, Navy, and Air Force after 1 September 1952 should be denied the special pay now authorized.

"To be avoided, also, is the situation otherwise to be presented after August 31, 1952, - that is the situation of professional officers appointed in the same Corps, having the same basic qualifications, working side by side, yet receiving different rates of compensation. The proposed legislation being presented at this time is in the nature of an emer-

gency, to prevent the expiration on September 1, 1952, of the authority for special pay to physicians and dentists commissioned in the Armed Forces who enter upon extended active duty on and after that date. It provides for the extension of current pay provisions only until July 1, 1953, the date of termination of the 'Doctor Draft Law'. Prior to that date, it will be necessary to review the entire problem of ways and means of procuring for and stabilizing the careers of medical and dental officer personnel. It is reasonable to believe that, in the event we should lose the 'draft doctor', more effective procurement inducements will be required than these currently in effect.

"After September 1, 1952, even if the world situation were such as to permit a sizable reduction in our Armed Forces, the military services will of necessity, continue to have a need for replacement, both of Reserve officers returning to civilian life and of Regulars lost through retirements, deaths, and resignations.

"In conclusion, I wish to affirm my sincere belief that, if the present compensation of medical and dental officers is reduced by the amount of the special pay to which they are now entitled by law, the adverse effect on personnel of the Medical Services would be immeasurable. Procurement of career personnel, not only in numbers but of the requisite professional competence and ability, would be seriously curtailed, if not halted. Losses of Regulars by resignation (and the acceptance of resignations cannot, in fairness, be denied indefinitely) will surpass, in my opinion, all previous totals. I think, too, there can be little question but that inequitable and unfair treatment now will require on the part of the Armed Forces increased expenditures of time, effort, and money to procure even a token number of physicians and dentists for the Regular Services in the future. In the long run, to offset the lack of Regulars, the final result could only be to increase the number of Reservists who would be required to leave their communities and serve in the Armed Forces for varying periods; to be replaced at the completion of their service by other physicians and dentists similarly drawn from communities throughout the nation.

"None of us, I am certain, feel that such dislocation of physicians and dentists from their civilian pursuits is desirable, or even justifiable, except in times of national emergency. It is a result to be avoided if at all possible."

SECOND DIVISION MEDICAL NCO SCHOOL

1st Lt Joseph Israeloff, MSC, Medical Section, HQ FEC
Formerly with Medical Co., 9th Infantry Regiment, and 2d Medical Battalion

Combat medics earn their stripes the hard way in Korea. They wear those stripes because they merit them, because they won them by a display of field medical know-how and by sheer courage and guts.

But here is the problem that lies before them. These same medics when they return to the States, after the many long, hard months in Korea, and are assigned to hospitals or medical training centers, unfortunately find they cannot hold their stripes. They just do not know enough and the fault is not their own.

When they arrived in Korea, these high ranking NCOs were Privates or Privates First Class. Then, because of normal rotation of men and combat attrition rates, these same Privates and Privates First Class found

themselves holding down jobs of great responsibility on the hill or in the aid stations. They had a big job to do, an important job, and in most cases a dangerous job.

They proved they could care for the wounded quickly and effectively under the most difficult of combat situations. They proved they could evacuate the wounded under direct enemy fire. They deserved those stripes. There was no question about that.

Arriving in the States and assigned to hospitals and training centers, they suddenly found themselves confused. A doctor would request them to prepare for a thoracentesis or a paracentesis, and they would not know what he meant. In the medical training centers

they found they could not drill a group of recruits or prepare for an hour of instruction. They knew their field medicine all right, but they were helplessly lost in stateside medical installations.

Attempting to help these men, 2d Division officers came up with an answer in the form of the 2d Division Medical NCO School. Conceived by the former Division Surgeon, Lt Colonel Robert M. Hall, and with the cooperation of all the medical officers of the division, the school was designed to give these NCOs working knowledge of actual hospital procedures and probable duty assignment in training centers.

Men selected to attend the school had to be especially selected sergeants of the first three grades who had at least six months of Korean duty behind them. They received one week of intensive formalized classroom work at the 2d Division's Medical Battalion, and then two and three weeks on-the-job training at the 8063d MASH and the 121st Evacuation Hospital.

At the Medical Battalion, the men were taught courses in anatomy, physiology and pharmacology, special hospital procedures and hospital administration by medical officers who aimed their discussions at a level easily understood by the sergeants. Yet all these courses were comprehensive enough to give the NCOs more than just a cursory knowledge of the subject. The medical officers selected to teach a specific course were chosen on a basis of showing an interest in or having a specialized knowledge of the subject. Thus the level of enthusiasm reached by the doctors was carried home to the students.

Non-medical aspects of the training included hours

in leadership, methods of instruction, and the conducting of classes on drill and calisthenics by the individual NCOs themselves.

The on-the-job phase of their training met with the complete enthusiasm and cooperation of officers of the 8063d MASH and the 121st Evacuation Hospital. Second Division NCOs had an opportunity to work in surgery and on the wards of these two fine hospitals. Nurses and medical officers explained every aspect of hospital functioning. Then the sergeants went ahead and did the job. They learned by doing.

Upon satisfactory completion of their training at the hospitals, the men were presented with a certificate of completion signed by the former Second Division Commander, Major General Robert N. Young, and the present Division Commander, Major General James C. Fry. A copy of this certificate was included in each man's 201 File.

Without exception, these Second Division NCOs returned to their units with a new won confidence in their medical ability and their certainty they could learn and handle any job assigned them in a stateside hospital or training center.

In the words of General Young, "These men who had earned their stripes the hard way in the rugged blood-stained hills of Korea, could now return to new assignments in the states and continue another good job, a job in which they could relate their Korean experiences to the advantage of the greatest Army medical service the world has ever known."

EXTENSION EXPIRATION DATE BLOOD GROUPING SERUM

The following is an extract from DA Cir 63, 22 July 1952, quoted for information and guidance of all concerned:

"II...BLOOD GROUPING SERUM, ANTI-B, LIQUID, 5 CC. - A 6 months' extension of the current expiration date of standard stocks of Blood Grouping Serum, Anti-B,

Liquid, Sec: Sufficient for 125 tests. Potency 12 months (Medical Stock No. 1-598-400) Lots 286-B, 289-B, and 294-B manufactured by Michael Reese Research Foundation is authorized. Accordingly, stocks of the above item should be used until 6 months past the current expiration date shown on the package. (AG 444.2 (17 Jul 52) MEDDE)"

AWARDS TO ARMY MEDICAL SERVICE PERSONNEL

The following additional Army Medical Service personnel have been awarded the Distinguished Service Cross, Silver Star, Legion of Merit, Soldier's Medal, Bronze Star Medal with "V", Bronze Star Medal or Commendation Ribbon for exceptional bravery in face of the enemy and meritorious service during the Korean conflict. The names of those who have received decorations and awards are based upon an MRU roster prepared by the Adjutant General's Section, Far East Command, as of 25 July 1952. Since the beginning of operations in Korea, 4,107 awards and decorations have been presented to Army Medical Service personnel.

DISTINGUISHED SERVICE CROSS

Trenholm, Richard R., Pvt

SILVER STAR

Buck, Raymond J., Cpl
D'Attilio, John A., Sgt
Dewitt, Lacy H., Jr., Sgt
Diliberti, Anthony, PFC
Dougherty, Eugene G., Cpl
Eggleston, Duane G., Cpl
Gundlach, Raymond, Sgt
Jones, Miles H., Sgt
Jump, Raymond A., Cpl
Lawrie-Smith, Robert, Sgt
Lee, Tidd Jack, PFC

Lindsey, Douglas, Lt Col, MC
Meadows, Floyd M., Sgt
Melvin, Karl M., Sgt
Sabol, John, Pvt
Seltzer, Oscar, Sgt
Smith, Benny H., Cpl
Stultz, Roger P., PFC
Whalen, James T., Sgt
Williams, Donald R., Cpl

LEGION OF MERIT

Bixler, John C. T., Lt Col, MC
Cafarelli, Roosevelt, Col, MC
Dickerson, Robert B., Lt Col, MC
Eckhardt, Richard H., Col, MC
Graham, James E., Col, MC

Moore, William A., Lt Col, MC

SOLDIER'S MEDAL

Conner, William A., Cpl
Hopkins, William C., 1st Lt, MC
Miles, Irl, M., SFC
Monroe, Everett, L., PFC

BRONZE STAR MEDAL with "V"

Akens, Lawson M., Sgt
Allen, Lloyd B., Sgt
Badger, John, PFC
Betts, Joseph E., Pvt
Bost, Joseph E., 1st Lt, MSC
Burnett, William A., Cpl

BRONZE STAR with "V" (Contd)

Campbell, Robert T., Cpl
 Connor, Joseph D., 1st Lt, MC
 Cruz-Morcello, Jaime, Sgt
 Daubert, Wayne R., Pvt
 Dias, Rodney A., Sgt
 Eikenbary, Raymond, Sgt
 Garney, Albert P., Sgt
 Goodall, John E., PFC
 Graeff, Clarence E., PFC
 Gundrum, Denis F., PFC
 Henry, James W., PFC
 Jackson, Norris, 1st Lt, MSC
 Jermyn, John W., Capt, MC
 Johnson, Leonard F., Sgt
 Johnson, William H., 1st Lt, MC
 Kiely, William J., Cpl
 King, Junior D., Cpl
 Kober, Ronald W., Cpl
 Kondrup, Victor, Jr, SFC
 Kuck, Martin J., Sgt
 LaPerla, Salvatore, Cpl
 Lanning, Keith, 2d Lt, MSC
 Laurella, Ralph S., Cpl
 Martin, Louis G., 1st Lt, MC
 McClellan, Maurice, Pvt
 McKie, Joseph, Cpl
 Mercado-Perez, Ramo, PFC
 Murray, Talmadge D., Cpl
 Nelson, Howard B., Cpl
 Norian, Haig H., 1st Lt, MSC
 Philpot, Vanburen, Capt, MC
 Piper, Robert L., Sgt
 Price, Clarence H., Pvt
 Ramirez, Frank, PFC
 Ramirez-Kohl, Emili, 1st Lt, MC
 Rivera-Hernandez S., Sgt
 Short, Charles F., 1st Lt, MSC
 Steinbrecher, Jerome, Sgt
 Thompson, John W., 1st Lt, MC
 Thorpe, Osburn, PFC
 Vandermeuse, Francis, Pvt
 Wagenman, Kenneth O., Sgt
 Walters, Maurice D., M/Sgt
 Weese, Robert E., PFC
 Weller, Earl J., Sgt

BRONZE STAR MEDAL

Alfred, Lois H., Maj, ANC
 Allen, Donald W., Sgt
 Anderson, James A., SFC
 Anderson, Arthur A., M/Sgt
 Andrews, Paul K., Cpl
 Andrews, William S., 1st Lt, MSC
 Angelich, Mary E., Capt, ANC
 Anglin, Thomas W., Maj, MSC
 Anzures, Alfonso, P, Sgt
 Arians, Marvin G., M/Sgt
 Asbury, William C., SFC
 Baker, Mescal, Maj, ANC
 Balliet, Charles M., Maj, MC
 Balliet, Charles M., Maj, MC
 Barnett, Herbert C., Capt, MSC
 Barr, John W., Maj, MSC
 Beatty, Ted W., Cpl
 Beck, Roswell N., Capt, MC
 Berninger, Howard G., Capt, MC
 Bennett, John C., 1st Lt, MSC
 Black, Harvey S., Cpl
 Blanke, Robert G., 1st Lt, MC
 Bliss, Howard S., Capt, MC
 Bolden, Frederick E., Cpl
 Bolton, William M., 2d Lt, MSC
 Bosco, Edward J., Capt, MSC

Brackins, Ollie L., SFC
 Brandt, Margaret M., Maj, ANC
 Broun, James R., Lt Col, MC
 Brown, Charles H., M/Sgt
 Bryan, Charles H., Sgt
 Buckler, Phillip, J., Lt Col, MC
 Bullock, John B., Capt, MC
 Byrd, Cameron W., M/Sgt
 Byrne, Robert A., Capt, MSC
 Cabell, Ben M., 1st Lt, MSC
 Carlton, Lawrence E., Capt, MC
 Carroll, Francis L., Lt Col, MC
 Carter, Robert, Sgt
 Carter, Donald C., Capt, MC
 Chan, Raymond, Capt, MC
 Clark, Harold T., 1st Lt, MSC
 Clifton, Charles A., Capt, MC
 Cochran, Robert E., Sgt
 Cole, Charles J., Sgt
 Collins, Lyle D., Sgt
 Cook, Clarence H. Jr., 1st Lt, MSC
 Corbett, James T., Capt, MC
 Cordell, Kenneth R., M/Sgt
 Counts, Edward F. Jr., Lt Col, MC
 Crimen, John C., Capt, MSC
 Darovich, Robert G., Sgt
 Davidson, Sidney L., Maj, DC
 Davila-Carrion, Sgt
 DeLaVega, Raul E., Maj, MC
 DeSaoPaulo, Silvi, Maj, MC
 Deitlebaum, William, SFC
 Dennert, Walter G., Capt, MC
 Derstine, Paul A., SFC
 Durham, John W., Capt, DC
 Eagen, John G., Sgt
 Emerson, Wayne D., 2d Lt, MSC
 Evans, George V., Maj, MSC
 Finkle, Kenneth G., SFC
 Fortson, Luther G., Capt, MC
 Free, Robert R., Sgt
 Gair, Edward A., Sgt
 Galarza, Vincente, Cpl
 Garcia, David F., M/Sgt
 Gates, Kenneth L., Sgt
 Gephart, Stanton L., Capt, MSC
 Gillard, Marjorie G., Maj, ANC
 Gillies, William G., Capt, MC
 Goetzinger, John Jr., M/Sgt
 Goldfein, Samuel, Capt, MC
 Gracia-Colon, Francis, Cpl
 Griffin, Herschel E., Maj, MC
 Guthridge, George B., Capt, MSC
 Gutz, Louis A., M/Sgt
 Hageman, Julius H., Cpl
 Hamilton, Robert L., M/Sgt
 Harris, Harley H., Jr., 1st Lt, MSC
 Harrison, Howard W., Sgt
 Harsh, Griffith R., Capt, MC
 Helms, Frank S., Cpl
 Helzer, Leon L., PFC
 Hendrix, Joseph P., Capt, MC
 Hill, Mark P., Cpl
 Hodge, Kenneth K., Maj, MC
 Hohl, John U., Sgt
 Holland, Herbert H., Sgt
 Hopkins, Joseph Jr., Sgt
 Hornbostel, Donald, Cpl
 Humphrey, Robert R., Capt, DC
 Huntley, Robert E., SFC
 Jernigan, Herbert D., SFC
 Jelenc, Milan E., SFC
 Jetland, Robert I., Maj, MSC
 Johnson, Joseph E., Capt, MSC
 Johnson, Maynard L., 1st Lt, MC
 Johnson, Orville D., Sgt
 Johnson, Stanley T., Sgt

Johnson, Carl H., Capt, MSC
 Johnson, Chester H., Sgt
 Johnson, Mark R., Maj, MC
 Jones, Moses J., Sgt
 Jones, William B., Lt Col, MC
 Juffey, Aloysius D., Capt, MC
 Kaplan, Morton, Capt, MC
 Kerrison, Juniper, Capt, MC
 Killman, Charles, Capt, MSC
 Knapp, Robert A., SFC
 Knight, Claude B., Lt Col, MC
 Kondo, Tak T., 1st Lt, MSC
 Kretchmar, Howard L., Capt, MC
 Kubicek, Richard B., Sgt
 Laird, Paul C., Capt, MC
 Lancaster, Carolus, Maj, DC
 Lankford, Tommy O., Sgt
 Lebeuf, Leroy L., 1st Lt, MSC
 Ledbetter, William, Capt, MSC
 Lee, Buford A., M/Sgt
 Leeling, Wendell F., Sgt
 Leeman, Raymond N., Sgt
 Limosani, Michael A., Maj, MC
 Lervik, Reuben R., Sgt
 Ligon, William G., 1st Lt, MSC
 Losornio, Felix R., Maj, MSC
 Malvern, John E., SFC
 Mantel, William, SFC
 Martinez, Louis R., Sgt
 Maxwell, Wayne L., Sgt
 Maybaum, Walter F., Capt, MSC
 Mayfield, Boyd A., Capt, MSC
 McMahan, William T., Capt, MSC
 Miley, John F., Maj, MC
 Miller, Emmett D., Sgt
 Miller, Harold S., Capt, MSC
 Miller, Lawrence T., Maj, MSC
 Miller, Richard T., M/Sgt
 Mitchell, Daniel A., Maj, MC
 Munoz-Rivera, Angel, M/Sgt
 Morgan, Richard Y., Capt, MC
 Mothershead, John L., Maj, MC
 Muniz, Manuel R., Capt, DC
 Murphy, Raymond J., Cpl
 Nagel, Robert L., Capt, MSC
 Naiman, Orlin F., Sgt
 Neagle, Paul E., 1st Lt, MC
 Neilander, Bernard, Capt, DC
 Newell, Robert B., Lt Col, MC
 O'Reilly, Curt M., Capt, MC
 Olin, Morse E., Maj, MSC
 Olson, Maxwell T., SFC
 Pagano, Philomena A., Maj, ANC
 Patterson, Truman, Cpl
 Patterson, John C., Lt Col, MC
 Perry, Lawrence E., SFC
 Pickens, Erskine G., 1st Lt, MSC
 Plott, Edgar N., 1st Lt, MSC
 Plucknett, Albert J., SFC
 Pond, Nathaniel H., Maj, MSC
 Rattan, Volney H., Lt Col, MC
 Reeb, Blanchard B., Maj, MC
 Reid, Roger S., 1st Lt, MC
 Riggan, John W., 2d Lt, MSC
 Rippee, Robert L., Capt, MSC
 Rollins, Robert L., Sgt
 Rossing, Robert G., 1st Lt, MC
 Sapp, Oscar L., Capt, MC
 Selby, Dale F., PFC
 Sharp, Clyde E., M/Sgt
 Shelby, Thomas A., Cpl
 Shepherd, Bob J., M/Sgt
 Shulman, David N., Capt, MC
 Simms, Charles T., 1st Lt, MSC
 Snyder, Bert L., Sgt
 Soontay, Howard Jr., Cpl

BRONZE STAR MEDAL (Contd)

Spitz, Harry, Lt Col, MC
Starling, William, Sgt
Stream, Lawrence, 1st Lt, MC
Studley, Warren L., SFC
Tax, Herman, Maj, VC
Tietz, Roy H., Sgt
Titus, Elbert D., SFC
Tolliver, Charles P., SFC
Tourtellotte, Charles, 1st Lt, MC
Travers, William J., Capt, MC

Tucek, Arthur R., Capt, MSC
Upchurch, Kent P., Maj, MC
Ventimiglia, William, Lt Col, MC
Wagenbach, William, Capt, MC
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ESSENTIALS OF PREVENTION OF COLD INJURIES

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TROOPS must be taught that COLD and IMMOBILIZATION of the soldier are the two primary causative factors in the production of cold injuries, i.e., frostbite.

Man has no control over weather conditions per se. Familiarity with simple meteorologic phenomena can lead to the administration of the cold weather effects on the individual in a given activity. Our experience following the installation of weather stations in combat units in Korea during the cold weather of 1951-52 leads us to believe that weather information and simple weather predictions can be applied with great advantage in the planning of tactical operations for the following day with regard to gear to be worn, extra gear to be carried, and duration of activity.

Immobilization of the soldier is a major factor that can often be altered by the unit commander. Immobilization occurs when the soldier is pinned down by enemy fire, placed on guard duty, assigned to an outpost position, ambush patrol, or placed in a motor movement. A man is considered to be immobilized when he is unable to move about freely due to a situation beyond his immediate control or through his own neglect such as, falling asleep while exposed to the low ambient temperature. It is during immobilization that the majority of cases occur. The attack on the problem of immobilization in low ambient temperatures resolves itself into two general components. First, by minimizing immobility (increasing physical activity) of the troops, and second, by utilizing the proper clothing including foot and hand gear.

WEATHER

All soldiers and particularly the platoon leaders, company commanders and battalion commanders, should be familiar with a few simple weather conditions, such as:

Temperature. When the estimated minimum temperature is low, then steps must be instituted to shorten the exposure and immobilization time of the soldier. For example, with an ambient temperature of 20 degrees Fahrenheit, one should not allow the exposure - immobility period to exceed six hours.

Wind Velocity. The higher the wind velocity the

greater is the rate of cooling or the loss of body heat for the exposed soldier. If tactically possible, one should provide wind breaks for men exposed on outpost, guard post, or on open moving vehicles.

Humidity - Dew Point. Unit commanders should be familiar with this term and how the dew point is determined. Evening dew points form the basis of estimations of expected low temperatures for the next twelve hours. The instructions for determining the dew point and making simple weather predictions are now in the hands of personnel operating in the Regimental Weather Stations.

Unit commanders at all levels should be familiar with the utilization of available weather data, weather predictions and ground surface conditions.

Body clothing, hand and foot gear should conform to the existing weather conditions. Changes in the equipment of the soldier should be based upon the predicted weather. Movement of troops on foot that will be followed by a period of immobilization due either to enemy fire, guard duty or ambush positioning, will require a change of socks between the period of immobilization in order to lengthen the exposure period. This must be anticipated in planning the tactical operation with consideration for the weather and ground surface conditions to be encountered. If this is not done the soldier will start into the period of immobilization with gear saturated with sweat which conducts heat rapidly away from the body. The same consideration applies to the soldier who will wade a stream or possibly break through the ice during the operation.

Some existing weather conditions will require shortening of exposure such as, on ambush patrol, outpost guard, general guard or motor movements in necessarily open vehicles despite the adequacy of furnished gear and the proper use of such gear. This can frequently be anticipated by an appraisal of the existing weather conditions and the prediction of the next twelve hour period. If a motor movement requires more than one hour it should be the convoy commander's responsibility to DISMOUNT all troops hourly and see that each individual soldier engages in physical activity for five to ten minutes. This activity should be vigorous enough

to produce adequate rewarming yet short of causing excessive sweating. In February 1951, a non-stop six hour movement of one battalion resulted in 110 cases of frostbite.

The production of frostbite is not only dependent upon low ambient temperature but also upon the condition of the ground surface. In this connection, decision for the wearing of various types of gear, namely, leather combat boots as opposed to shoe-pacs or rubber insulated boots, should be predicated not only upon the prevailing weather and ground surface conditions, but also upon anticipated and predictable weather. If one unit commander in November 1951 had made the correct estimate of the situation in regard to potential weather and ground surface conditions, he would not have subjected his troops to falling temperatures and wet ground surfaces while wearing leather combat boots when the already issued shoe-pacs had been left in the rear areas in his regimental supply train. This example of mis-judgment plus a second in another unit, contributed one-third of the total number of cases of frostbite for 1951-52.

GENERAL BODY CLOTHING

A standard number of layers of clothing cannot be prescribed for universal wear throughout the winter. Weather does change rapidly and unit commanders must be constantly aware of these variations in advance so as to regulate the body clothing worn in a given operation under given weather conditions. The basic recommendations from the Quartermaster Corps relate to only a standard weather type uniform. These recommendations were not intended to exclude unit initiative in the selection of gear as weather changes occur. The decision to don or doff certain items of body clothing should not be Army-wide with respect to time. Flexibility must be provided for local conditions. Certain basic principles regarding body clothing are frequently overlooked or neglected. This includes the ventilation of the body during physical activity, cleanliness of clothing to prevent loss of insulation and the avoidance of constriction, such as is produced by snug fitting of underwear, sweaters, jackets and trousers. This also includes the securing of trouser legs by means of rubber bands or lacing too tightly the top of the boots at the level of the calf.

FOOT GEAR

It is strongly recommended that soldiers whose duties confine them to the regimental areas during combat should be equipped with rubber insulated combat boots.

Rubber Insulated Boot:

Proper fitting is even more important in this type of footgear than in the shoe-pac or leather combat boot. The responsibility of proper fitting for the individual soldier must rest directly upon the small unit commander, i.e., platoon or section leader.

Sock Gear. Emphasis must be placed on the use of a single pair of wool cushion sole socks. Ski socks or two pairs of cushion sole socks are constricting combinations.

Sock Exchange. Exchange of the sock is even more important in foot hygiene with this boot because of increased sweating, retention of sweat and of increased tendency for epidermophytosis. Although sweating in this boot does not contribute to the

loss of insulation, it nevertheless may lead to the problem of maceration. Maceration as used here is the softening of the sole of the foot by retained sweat or water. Trauma to a macerated foot as is incurred in walking will produce denudation or loss of skin of the sole. These denuded painful feet will require hospitalization for a period of 5 to 10 days. Directives stating that socks will be exchanged once daily will not always suffice. Unit commanders must be prepared to carry out individual sock exchange when the occasion demands.

Shoe Exchange. Whenever possible, with the tactical situation permitting, the individual soldier should be allowed to don the leather combat boot or expose his feet for drying in order to avoid excessive maceration.

Shoe-pac:

Sock Gear. In spite of carefully worded directives, many wrong combinations of socks were seen this past year. Twenty percent of the cases of frostbite for 1951-52 were combinations which can be broken down into a constrictive type (12%) and insufficient insulation type (8%). Constriction was produced by the wearing of three pairs of wool ski socks, two pairs of wool ski socks, plus one pair of cushion sole socks, or two pairs of wool socks of the same size. Lack of insulation occurred in the wearing of one pair of ski socks, one pair of cushion sole socks, two pairs of cushion sole socks or the absence of innersoles.

Innersoles. Present directives state that innersoles will be changed at least once daily. Many times the occasion will arise where the man has to wade through streams of water or indulge in very strenuous physical activity with excessive sweating which will require the wet innersole to be replaced with a dry one in order to preserve the insulation and avoid excessive loss of heat from the extremity. These conditions may demand a change of innersoles several times a day. Unit commanders in planning operations should take this fact into account and institute steps in advance to provide an extra supply.

Extra Socks and Innersoles. A survey of the cases of frostbite this past year reveals the fact that 30% of the cases did not have available the extra components of sock gear and innersoles for change. It is not known if this break in discipline was due to failure of supply, inattention by the unit commander, or sheer neglect of the individual. Further analyses reveal that 33% of the cases of frostbite failed to comply with the directives in that sock and innersole exchange would be accomplished at least once daily. Again, there is no assessment as to whether the failure was due to inattention by the small unit commander or neglect on the individual soldier's part. These above errors in discipline occurred despite the fact that the tactical situation was relatively static and there was no apparent disruption of supply or command channels by enemy action. It is conceivable that opportunities for sock exchange do occur even in certain types of action and extra gear of this type should be carried. The small unit commander should not assume that a given tactical station will prevent the man from replacing wet socks with dry ones. He should be able to foresee such possibilities and direct the troops to carry this extra gear. The story was told many times this winter by individual soldiers that they were ordered by their platoon leaders to strip themselves of all extra gear because of a particular op-

eration that was to take place. Many soldiers stated that they discarded their extra socks at this time, believing that they were following the order as issued by his platoon leader. During the ensuing operation there was wetting of the feet either by wading through streams or by excessive sweating through vigorous physical activity. This was often followed by positioning of these men on an outpost, guard or ambush patrol where he was immobilized for a period of time with wet feet. Such incidences resulted in the loss of manpower by frostbite.

HAND GEAR

To date, there are no provisions made for the immediate replacement of hand gear which has become wet, torn or lost during a tactical operation. Although extra inserts are often provided, no provisions have been made for the replacement of the outer shells which frequently became wet. In addition, the manning of certain weapons and the execution of many procedures in a tactical operation, using the present prescribed hand gear necessitates removal of this hand gear to perform the task. It is strongly recommended that all soldiers undergo repeated periods of supervised practice in handling their weapons while wearing the complete mitten ensemble. These practice sessions should be conducted by the squad and platoon leaders throughout the winter whenever the tactical situation permits. It would be a major contribution if a type of hand gear could be designed that would be impervious to moisture and yet permit dexterity. These above statements are based upon many observations in the two previous winter campaigns in Korea. One example is the inability of the company aid man to apply dressings, administer morphine or plasma without removing his gloves. Other examples include inability to pull grenade pins, the unjamming of weapons and the manipulation of sighting mechanism of various weapons. Lacking hand gear of the above recommended design, and in order to prevent the loss of hand gear, it is strongly recommended that the hand gear be secured to the individual by the use of a neck cord or some other similar device. Many men in order to obtain dexterity substitute the five finger gloves for mittens. This substitution though providing some increased dexterity leads to a greater loss of body heat and insulation. This substitution contributed materially to the number of cases of frostbite of the hands this past winter.

GENERAL STATEMENTS

In the first period of instruction on cold weather, Trenchfoot and Frostbite should be clearly defined in lay terms for the soldier.

Many frostbitten soldiers this past winter stated, "I didn't realize frostbite was so serious. I could have been more careful." Soldiers must be made to recognize Frostbite as a serious injury. This may best be done by stressing the following:

Frostbite is more than a mere "Nipping" by cold.

To incur a severe frostbite it is not necessary to have a solid freeze of the foot or hand.

Frostbite will require a long period of hospitalization. Undesirable features of this hospitalization are - a long period of confinement to bed, no pass privileges, and no smoking until discharged.

The damage caused by frostbite can result in loss of all or part of a foot or hand.

Frostbite will cause the injured part to be extremely sensitive to cold for many years. During cold weather the formerly frostbitten part will be cold and painful.

It is recognized in winter operations that there is a shortage of water in the forward areas. It is felt, however, that by an even more judicious use of available water, more frequent opportunities for bathing the feet can be provided.

It is absolutely mandatory that the squad leader examine the feet of his men daily. The medical corpsmen assigned to the platoon must inspect the feet of the platoon at least three times a week. During the inspection by these two groups of individuals, particular attention should be paid to the combination of sock gear worn, the cleanliness of sock gear, the sizing of the foot gear, the cleanliness of the feet, and evidence of areas of constriction of the tips of the toes and along the site of the great toe, as well as, at the ankle and lower calf levels. Unit commanders should not be satisfied with merely issuing the order to squad leaders to inspect the feet daily but should call upon such squad and section leaders for a report of their inspection. This can be verbal to simplify the procedure. Similarly, the demand for such reports can be carried upward through the command to the regimental level as a check on the execution of such orders which is important to the prevention of cold injury. In this fashion, deficits in supply, lack of understanding of earlier orders, and other correctable conditions can come to the attention of the command.

MISCELLANEOUS ITEMS OF PROPHYLAXIS

The individual soldier should be taught that even during periods of immobilization he can carry on physical activity or movement without exposing himself to the enemy, thus preventing cold injury to a great extent. The individual should begin his movements long before the appearance of the warning sign of cold injury, namely, numbness and/or the sensation of cold. In order to insure that the individual is carrying on physical movement, it should be the responsibility of the squad and platoon leaders to frequently check on the individuals when they are stationed on outpost duty, guard duty, riding a vehicle or any other occasion when tactically possible.

Warm-up huts during cold weather combat are absolutely necessary. Whenever tactically possible the man should be provided an opportunity to rewarm himself in such facilities.

Two general groups of individuals who contribute materially to the overall number of cold injury cases are the new recruits coming into the line for the first time and the soldier who has been in active combat for prolonged periods of time without rest, that is, 30 days or more. Squad leaders must pay particular attention to these individuals. The new soldier although he has received indoctrination still lacks the field experience in the application of cold weather principles. He will require the personal individual supervision of the squad and platoon leader through the critical period of the first fourteen days in combat. The soldier who has been in active combat 30 days or more without rest becomes careless in his compliance with the basic principles in the prevention of cold injuries. His personal habits including foot hygiene fall below desired standards because of his state of physical

and mental exhaustion.

There are two other groups of individuals who contribute to the increase in the overall incidence of frostbite. The first group is the Negro. Regardless of all contributing factors, the Negro in a regiment is six times the risk for cold injury as compared to the White. All squad and platoon leaders should be cognizant of this fact and during periods of extreme cold weather coupled with immobilization, take steps to see that this group is given even greater personal attention in employing all previously enumerated measures in the prevention of cold injury. The second group which contributes to the bulk of cold injuries comprises soldiers who originate from those states listed in the Appendix. Squad leaders and platoon leaders should know by name those individuals originating from these areas. During periods of cold and immobilization they should pay special attention to this group to preclude an increase in cold injury.

COMMAND RESPONSIBILITY

The chain of command in the prevention of cold injuries should work in both directions. Too often errors in supply, rotation of personnel, or altering of tactical operations are reported by the small unit commander but are ignored or passed over by the higher echelons who do have the authority to institute promptly the worthwhile corrective measures.

Repeated indoctrination of soldier in the principles of prevention of cold weather injuries is mandatory. This indoctrination must be carried on by the squad and platoon leaders. Repetition makes for learning. Indoctrination should be instituted long before the onset of cold weather and not after the first cases of cold injury occur.

PSYCHOLOGIC ASPECTS OF UPPER GASTRO-INTESTINAL DISORDERS*

Part I by Capt Milton Levine, MC, 141st General Hospital, APO 1005

Part II by Capt Clifton C. Rhead, Jr., MC, 141st General Hospital, APO 1005

PART I

FROM the time the 141st General Hospital began functioning in this area in December of 1950, through May of 1952, about 1950 medical patients were treated on an in-patient status. Of this total number, 11%, or 211, were admitted for peptic ulcer, either diagnosed or suspected. Of these 211 patients, 105 (or 5.5% of all medical patients admitted) proved to have either gastric or duodenal ulcers, and 94 (or 5% of all medical patients) were found to have no demonstrable lesions on x-ray examination. The vast majority of this latter group was ultimately diagnosed as having Psychogenic Gastro-Intestinal Reaction. The remaining 12 patients were transferred to other hospitals before a diagnosis could be determined during the early days when this facility was not yet equipped to render maximum diagnostic examination and treatment in this type of case. From these figures, it can readily be seen that it has been the experience at this installation that of all patients admitted with the suspected diagnosis of peptic ulcer there is roughly a 50-50 chance that subsequent examination will reveal no organic pathology.

It has been variously estimated that about 10-20% of all ulcers are missed in upper Gastro-Intestinal

All combat units of company size or larger should have a Cold Injury Control Officer. It should be his duty to promote the training of troops for cold weather operations, advise unit commanders on errors in supply and utilization of personnel in tactical operations. He should investigate the causative factors in each case of cold injury within his unit. He should be allowed freedom of thought and investigation so that there will not be a "white-washing" of the circumstances which lead directly to the production of cold injuries, such as "too heavy enemy action," "weapons jamming," etc.

The unit commander who runs his cases "underground" in order to preserve or present a good record should be relieved of his command. Once a soldier has incurred a bona fide cold injury he should promptly be evacuated. Retention of this individual within the unit may upon subsequent re-exposure to cold develop an even more serious degree of injury. It is a well established fact that individuals with a mild to moderate degree of frostbite are more susceptible to cold than the uninjured individual. The already injured soldier is a distinct liability to his unit in subsequent tactical operations during cold weather.

APPENDIX

States Whose Minimum Temperature for the Month of January is 20° F or Higher

Indiana	Oklahoma	Georgia
Missouri	North Carolina	Arizona
New Jersey	Arkansas	Mississippi
New Mexico	Oregon	South Carolina
Ohio	Tennessee	Texas
Pennsylvania	Virginia	Alabama
Rhode Island	Washington	California
Kentucky	West Virginia	Louisiana
Maryland	Delaware	Florida

x-ray examinations. This includes both gastric and duodenal ulcers. These percentage figures are, of course, based only on clinical impressions since cases where no pathology is found by x-ray usually do not reach surgery. On the other hand, in most series of studied cases, about 1 plus percent of the cases thought to have duodenal ulcer by x-ray proved to have no evidence of disease in the duodenum at surgery'. The percentage of accuracy depends greatly upon the experience of the examiner, his meticulousness and his technique.

Since Gastric Mucosal Prolapse has recently been offered as the etiology for epigastric distress, I would like to digress for a moment to say a word about a recent study by Levin and Felson.² They performed upper Gastro-Intestinal Roentgen studies in 100 patients who were chosen because they had no gastro-intestinal symptoms. Gastric mucosal prolapse was encountered in 18 of the 100 cases. The prolapse was considered slight in 10, moderate in 5, and marked in 3. Because of the high incidence of this finding in patients without symptoms, they concluded that the clinical significance of gastric prolapse has been over-emphasized and that it is seldom the cause of symptoms.

Peptic ulcer, as any other disease picture, has what is often referred to as "the classical picture."

*This paper was presented at the Second Kyushu Medical Conference, Fukuoka, Kyushu, Japan, 20 June 1952.

This should be considered as the base-line for further investigation rather than the diagnosis *per se*, since even though the history appears to be of the characteristic or near-characteristic type, it must be remembered that the technique of questioning all too frequently determines the response. The majority of the patients admitted to this installation with complaints of epigastric distress have had symptoms for a considerable length of time and usually they have been seen previously and questioned by several doctors. From these interviews and examinations they may acquire medical information concerning their symptomatology which serves to color their subsequent question responses, making interpretation more difficult. The history may become more and more glib and characteristic with the subsequent tellings. The patient may have been previously told by a physician that he had an ulcer. This diagnosis, whether or not based on accurate Roentgen studies, serves to consolidate and emphasize the patient's symptoms and even direct his use of descriptive terms which he may or may not clearly understand. In essence, the patient has consciously accepted the proffered diagnosis, and almost subconsciously the symptoms are made to fit the pattern he has learned is expected in the condition. This fixation of symptomatology in the upper Gastro-Intestinal tract is particularly significant because of the strong emphasis which the stomach and duodenum apparently receive in somatization of emotional conflicts.

Gastric neuroses show a great variety of symptoms based on disturbances of the secretory and motor functions of the stomach and duodenum, making it frequently difficult to differentiate between neurogenic and organic factors. Many functional gastric symptoms are secondary results of faulty eating habits. On the other hand habits such as incomplete mastication, fast eating, air swallowing, immoderation and unwise selection of food are frequently the expressions of emotional conflicts and so these eating habits can also be considered as psychogenic. Nervous disturbances of the stomach may range from slight postprandial distress, heartburn, anorexia, regurgitation and eructation of gas to severe epigastric pains and intractable vomiting. Comparative clinical studies conducted in the Chicago Institute for Psychoanalysis³ have shown that in all patients suffering from psychogenic gastric disturbances, a predominant role is played by the repressed help-seeking dependent tendencies. There is a strong fixation to the early dependent situation of infancy and this comes into conflict with the adult ego, resulting in hurt pride. Since this dependent attitude is contrary to the wish for independence and self-assertion, it must be repressed. This type of conflict is most conspicuous in cases of peptic ulcer.

It is common medical knowledge that all functional gastric symptoms are influenced by worries, fear, family quarrels, business reverses, overexertion and exposure to danger. The latter two are particularly important in any war zone. The common denominator in these emotional tensions is an intense longing by the individual for rest, security and help. The symptoms may resist all forms of drug therapy while the individual is still in his stressful situation. Rest cures or changes of life situations are only symptomatic measures, since the stomach symptoms must be considered only as an indicator of an underlying personality disturbance. Undue attention (and here inaccurate diagnosis of a non-existent ulcer becomes important) given to these symptoms only supports the neurotic patient's evasion of those emotional problems which underlie the symptoms and thus

contributes to the perpetuation of the difficulty. Systematic psychotherapy directed toward the fundamental problems of the total personality is therefore indicated in all serious cases.

The following cases seen at the 141st General Hospital illustrate some of the points that have been mentioned.

Case Report No. 1: The first case is that of a 31 year old white male who was admitted after having been evacuated from Korea, with the chief complaint of intermittent epigastric burning of seven years duration.

Present Illness: The patient stated he first noted epigastric postprandial burning about seven years ago. The burning occurred about 1 to 1½ hours after eating, and lasted 1 to 3 hours. The discomfort began in the epigastric region and progressed up under the sternum. If he did not eat, he had no discomfort. There was no associated nausea or vomiting. The discomfort was relieved by "tums" and amphojel. Milk relieved the burning somewhat but not as well as did amphojel. He had his first GI Series in Belgium in 1945 and he was told it was negative. In November 1950 he had another GI Series and he was told he had a duodenal ulcer and was treated with banthine and diet, with a subsequent negative GI Series in January 1951. He had another GI Series in August 1951 but did not know the results. GI Series in November and early in December 1951 demonstrated "old scars." Two more GI Series in December were equivocal as was another in February 1952. Prior to transfer he was hospitalized at another military installation for 10 weeks and was treated with sippy and bland diet, antispasmodics, amphojel and banthine at various times. The patient felt that he had gotten along fairly well on bland diet but some foods still caused the burning sensation. It was felt by the transferring hospital that a great part of this patient's difficulties was due to psychogenic factors.

His past history revealed that his father had had stomach trouble for a number of years and that he had not been able to work since a cholecystectomy in 1948. Physical examination on admission revealed no abdominal tenderness to palpation.

Fully realizing that he had had considerable x-irradiation since 1950, it was felt that a combined cholecystogram and GI Series should be done, with minimal exposure. This revealed a normal gall-bladder and duodenal bulb, with pressure on the bulb from the gall-bladder.

The patient was referred to the psychiatrist who felt that he manifested a basic Passive Dependent Personality with Gastro-Intestinal Manifestations. A medical board recommended return to general service with waiver and that he be reexamined in three months and in the interim be reassigned in an area where psychiatric treatment was available.

This patient had ten complete GI Series, with nine of them done within a period of sixteen months. His history was characteristic of peptic ulcer only in the relief that antacids and bland diet offered. He was told on several occasions that he had a duodenal ulcer. This duodenal bulb deformity represented normal gall bladder pressure. In addition to undue X-ray exposure, the numerous examinations and interpretations served to "fix" his gastric neurosis.

Case Report No. 2: The second case is that of a 24

year old white male construction engineer soldier who was transferred to this hospital from a Hospital Ship with the chief complaint of constant indigestion over a seventeen months period.

The patient stated that for 6-8 months prior to coming on active duty with his National Guard Unit he had severe indigestion manifested by epigastric burning which extended up beneath his sternum, sharp left upper quadrant pains, frequent belching and passage of flatus. He had a GI Series and was told he had no ulcer but a "nervous stomach." He was put on a bland diet and improved. After he came on active duty in September 1950 his indigestion became worse and when he went to Korea in February 1951 it became still worse. In May 1951 he was hospitalized in Korea because his distress had become severe. He had two GI Series and was told he had an ulcer. At the end of 11 days of hospitalization, he was sent back to duty because, as he states, "a push was on and the hospital had to get out all available men." He continued to have trouble constantly and was again hospitalized in February 1952 and transferred a week later to this hospital. The patient said he had taken amphetamines almost constantly since being in the service. This gave temporary relief as did milk. Any greasy or field foods increased the epigastric burning as did citrus fruit. The patient said he had not gone a day without pain since coming on active duty. He had occasional nausea and vomiting. There had been no hematemesis or melena. He said his nerves were all shot because of his stomach trouble. He did not believe that the reverse could be true. During the examination he belched and passed flatus almost continuously.

The patient stated that for the past 5-6 years he had had difficulty seeing at night claiming that his "eyes got tired." His father has had a stomach ulcer. He was married and his wife had migraine headaches. His mother died from rheumatic heart disease after being an invalid for some time.

Physical examination was negative except for slight epigastric and left upper abdominal quadrant tenderness to palpation. GI Series was negative.

The patient did not respond to the usual ulcer regimen. He was seen by a psychiatrist who felt that he was overly conscientious with a driving ambition beneath which he was a markedly dependent individual as a result of maternal deprivation due to his mother's chronic invalidism. He was given an S-3 profile and it was recommended he be reassigned to Japan.

This patient's history was not characteristic of peptic ulcer, manifesting only intolerance to certain foods and temporary relief from antacids and milk. In addition, his admission history suggested strong psychogenic factors to the examiner.

Case Report No. 3: The third case is that of a 29 year old white male Field Artillery Officer who was transferred to this hospital from Korea on 27 January 1952, with the chief complaint of epigastric burning and nausea when under stress, of seven years duration.

He stated that he had had "heartburn" beginning about 30 minutes after eating since 1945, when he was in combat. He was hospitalized for 6 weeks at that time and was reprofiled because of what he recalled as "a nervous stomach or possible duodenal ulcer." He received a 10% disability from the VA for this condition after discharge but he stated that he asked to have the pension terminated about

a year later. He did fairly well under intermittent self medication until 1949 when while under tension in college his symptoms became more marked. He subsisted on baby foods and amphetamines. He continued to have similar intermittent episodes, resorting to diet and amphetamines for relief. There was marked nausea but only occasional vomiting. When he arrived in Korea in November 1951 his symptoms became much more severe. In addition to the epigastric burning he now noted sharp epigastric "pulling" pains and severe headaches. The sharp epigastric pain occurred in mid-morning, mid-afternoon, and occasionally awakened him from his sleep. This sharp pain was usually relieved by food but was aggravated by C rations. He now vomited frequently. He stated that he noted "chocolate colored lumps" in his vomitus. There was no melena.

The patient described himself as a "nervous person," always having been somewhat restless and ill-at-ease.

Except for tenderness to palpation in the epigastrium just to the left of the midline, physical examination was essentially negative. The GI Series was negative.

He was seen by a psychiatrist who felt that he was outwardly an independent individual beneath which lay many needs for dependency. He was given an S-3 profile and returned to general service with waiver for combat duty.

Seven years prior to being seen here this patient received a pension which proved to him that he had an ulcer. His outward manifestations of independence probably forced him to have the pension discontinued but his dependent needs continued as did his epigastric distress and the process of "fixing" upon his stomach as the source of his difficulty.

Case Report No. 4: The last case is that of a 37 year old white male Antiaircraft Officer who was a direct admission.

He had a GI Series at another military hospital a week prior to admission which demonstrated a duodenal ulcer crater. He was hospitalized because mess facilities in his unit were not considered suitable to adequately treat this condition. The patient's chief complaint on admission was abdominal pain of three years duration. He stated that he had had an almost daily "gnawing" or "hunger" pain since the onset of his present illness. The discomfort became aggravated between 1-1½ and 4 hours after eating and was relieved by food and milk. Soda bicarbonate offered transient relief. Since the onset he had been awakened from his sleep by the discomfort about 5 out of every 7 nights. He drank a glass of milk, got relief and returned to bed. For 6 months prior to this hospitalization he had been nauseated during the afternoons and occasionally vomited. No hematemesis or melena had been noted. He had had 3 periods in the past when the discomfort became much more marked than usual. These periods occurred in May 1949, October 1950 and February 1951. He had a GI Series on each of these occasions and they were reported as negative. He had never been on prolonged diet therapy. Two weeks prior to admission he began taking bethanechol but without relief. He felt that emotional stress aggravated his condition.

He came to Japan in January 1950 and had been stationed here since.

On physical examination there was slight discomfort to deep palpation just to the left of the umbilicus. Palpation in the epigastrium to the right of the midline caused referred pain in the area to the left of

the umbilicus. Otherwise, the physical examination was not remarkable.

The x-ray films from the examination performed a week before admission were available, and there was no question about the existence of an ulcer crater so the examination was not repeated.

He responded well to proper diet, antacid, antispasmodic and sedation. On admission the patient expressed a desire to see a psychiatrist to talk about the interrelationship of his discomfort and the conditions of stress he occasionally found himself in. A psychiatrist saw him and felt that the patient had marked dependent strivings which were denied by defenses of driving ambition and sarcasm in his relations with other people. He was discharged with an S-3 profile and sent to general service with waiver. Since he was stationed in the area, arrangements were made for him to be followed in this psychiatric outpatient clinic.

This last patient gave a more characteristic history, showed a duodenal ulcer on x-ray and manifested psychiatric aspects fundamentally similar to those of the three previous patients discussed.

CONCLUSION:

In conclusion, it is well to stress again the importance in upper gastro-intestinal disorders of considering the patient as a total personality with the knowledge that there are at least two aspects, the organic and the psychiatric, the question of the relative importance of each being a didactic one. The psychiatric aspect is however the one most frequently overlooked.

The four patients that have been discussed were seen in psychiatric consultation and the findings in these cases and on disorders of the upper Gastro-Intestinal tract in general are presented in Part II.

PART II

Internists long ago realized that all that goes wrong with the GI tract is not necessarily physical in nature. There is a functional circle determining how the stomach takes care of its food, and occasionally the circle becomes aberrant. The factors in its function have been the object of much physiological study, and yet we do not clearly understand the implications of all of the relationships. It has been difficult to unravel the physiological factors involved and to assign each of them its proper place. When we have difficulty understanding and establishing relationships through physiological experimentation, it is to be expected that there will be equal, if not greater, difficulty in establishing clearly the relationships of psychological phenomena and attitudes to the pathogenesis of upper GI disease. We believe that certain emotions, i.e., panic, helplessness and depression, inhibit the secretion of hydrochloric acid, and that others, i.e., anger, hostility, resentment and guilt, increase that secretion and if those observations are valid, then we have a starting point for the investigation of the problem along characterological and psychological lines.

It would be wise at this point to indicate the position of the psychiatrist in relation to the problem and to emphasize that it is not the relationship of an emotion or affect to the specific tissue change we call an ulcer that concerns us, but rather the relationship of those feelings to the changes in ac-

idity, motility, and tonus of the stomach. There remains an organic link between those stomach functions and the ultimate tissue change, the exact nature of which is as yet unknown. Thus, we do not propose that attitudes cause ulcers - many people with similar conflicts and character structures may not have ulcers - but rather we believe that emotions and attitudinal orientations may result in certain conditions which, if the unknown condition is present, result in an ulcer. Substantial direct and indirect evidence shows that increased hydrochloric acid production is essential in peptic ulcer formation, and it has been shown as well that vascular changes and mechanical factors may well play an important contributory role in the development of that disorder. However, further direct evidence is still needed as to the emotional processes that are associated with these physiologic changes.

It is significant that our first relationships with others are through the medium of the GI tract. One of the first instinctive feelings of the newborn child is the desire to be fed. It is primarily through that desire that the earliest relationship with the mother is established - necessarily a highly dependent relationship in which the infant remains dependent on the mother for food and for the continuation of life itself. Hunger is probably the most primitive form of discomfort and insecurity, the relief of that hunger thus comes to represent to the child the earliest form of security and love. Associated with the early centering of attention around the mother and upper GI tract are the other attitudinal characteristics of the infant, namely the need for protection and the desire to be taken care of.

Deprived of the satisfaction of his oral needs at this time, i.e., if the supply of milk is not sufficient for his gratification, the infant becomes aggressive, bites the breast, and becomes irritable. We recognize these stages in infantile development in psychoanalytic work and give them the names of the oral-receptive and oral-aggressive phases.

Certain people may, for one reason or another, retain some of the characteristics of those phases and integrate them into their later character structures. The desire to be taken care of and protected may become a primal need and with it the individual may retain the infantile psychic counterpart the desire to eat or to be fed. This constellation and the attitudes and emotions which are part of it, we refer to as orality. Having incorporated those characteristics into personality structure, the individual may then use the GI tract as a back-drop against which he dramatizes his psychodynamics.

The most succinct and explicit formulation found in the literature concerning peptic ulcer pathogenesis is that already referred to in Part I. Alexander and his colleagues at the Chicago Institute for Psychoanalysis believe that hyperactivity of the stomach functions of the ulcer patient is a direct expression of the infantile dependent needs of that patient. They state that intense oral-receptive and/or oral-aggressive drives, when frustrated either by the external environment or by the internalized character structure of the individual which makes acceptance and recognition of those drives incompatible with his conscious needs and desires, cause an unconscious equation of those drives with, and a regression to, early infantile desires to eat or to be fed. This, they state, is the fundamental psychological process in the production of an ulcer. Overt attitudes and behavior may vary, but the pro-

ness referred to is reported to be found invariably upon analytic investigation of the patient. It is believed that the unconscious desires to be fed or to eat, produced as indicated, are accomplished by the gastric hyperfunction necessary for the production of an ulcer. Such dependent patients respond with gastric hypersecretion, hyperemia, and hyperperistalsis in a variety of situations; for instance, such activity might be correlated with longings for care and for closeness in one patient and with anxiety and danger in another. Those emotions of anxiety and rage may be aroused when dependency longings, needs for self-aggrandizement or self-esteem, or needs for attaining certain ideals are aroused. Again, GI symptoms may develop when those needs are gratified if the patient has conflicts over accepting such gratification. Thus the GI symptoms represent an attempt to be cared for, to be fed; they may also represent an oral attack upon, a devouring, of the frustrating person, a cry for help, a plea of helplessness in the face of the anticipated counter-attack. The sequence of events frequently starts with a repression of frustrated dependency longings and the attempt to gratify those longings through the illusion of being fed. Thus, there are multiple emotional states to which the stomach reacts with hyperactivity. However, in all of these cases there is one common denominator; namely, that the peptic ulcer patient retreats from his rage and hostility into a dependent attitude and that the emotional state which is directly connected with the stimulation of the stomach activity is always an extremely dependent one. Sometimes it may be a dependent, receptive attitude; sometimes it is an aggressive demand for help. The first link in the chain is often rage and aggression; immediately, however, the patient retreats from his hostility, from his attack, and turns toward maternal love and assistance. A precise analysis will almost always show the last link in the chain of emotional events leading to symptoms to be a regression to early oral dependence and oral demands, and it is these regressive attitudes which are the immediate stimulus to stomach activity. (Alexander).⁵ That these statements need further validation, preferably by direct laboratory observation, is admitted, since there is no experimental evidence, positive or negative, concerning hydrochloric acid secretion associated with unconscious wishes to be loved, fed or to eat, as those wishes appear in personality investigations. However, the present evidence would seem to point to such a chain of events.

There are critics of Alexander's hypothesis who, basing their own hypothesis on anamnestic studies of ulcer patients and studies of the incidence of ulcer in certain life situations, believe that chronic anxiety plays the most important role in the etiology of peptic ulcer, and offer as partial evidence the fact that chronic anxiety is accompanied by increased HCl production. An individual extensively studied by Wolf and Wolff secreted more HCl during prolonged stressful situations than he normally did, and it was also their finding that the HCl production was diminished in a situation of acute panic accompanied by feelings of helplessness. Other investigators have reported similar responses. On the basis of these studies it is proposed that the gastric hyperfunction essential for the formation of an ulcer is definitely associated with chronic anxiety (chronic here referring to a process of prolonged duration), that if those two associated processes persist a peptic ulcer will develop, that it is not essential how the anxiety is produced or what its source may be, and that while the preceding conditions may vary, it is essential that the anxiety be of continuous, long

duration and that it be unrelieved either by the development of adequate defense mechanisms or by relief from the stimulating source of the anxiety. (Mahl).⁶ They discredit the essential importance of the oral mechanisms, and they reiterate that there is no experimental evidence, positive or negative, concerning HCl secretion in association with exacerbation of dependent strivings or needs and their unconscious equivalents of wanting to eat or to be fed.

Anxiety, however, is ubiquitous, and it would therefore appear meaningless to correlate somatic processes with anxiety itself, since the only meaningful correlation for psychosomatic research is between the somatic process and the method by which the personality defends itself against whatever anxiety is present, specifically, in the case of peptic ulcer, by oral, dependent defenses. (Szasz).⁷ Secondly, it is apparent that in the face of intense and unbearable anxiety, regression to oral defenses may occur, and it may be such regression rather than anxiety which results in stimulation and increase of gastric function. Thirdly, those who hold to an anxiety hypothesis have admittedly not subjected their patients to intensive analytic investigation which might demonstrate such dependent needs, and the investigation of Alexander and his group are not thus easily brushed aside.

I would like now to turn to a consideration of the case material already presented in Part I. You may have noticed the repetition of the psychiatric formulations in these cases: in all of them the concepts of dependency, aggressivity, and independence appear and reappear. Although overtly and superficially the patients' personalities differed remarkably, we were able in each case to demonstrate or to infer in these patients a retreat from a stressful life situation of dependence and longing for care and comfort (and I do not believe that we consciously or unconsciously made inference to fit in accordance with a preconceived idea).

The first case was that of a 31-year old officer, an evacuee from Korea, who had a chief complaint of intermittent episodes of epigastric burning of seven years duration. His personality was characterized chiefly by his placid, easy-going nature which was completely devoid of any hostile-aggressive components. He stated that he never became angry or even experienced feelings akin to anger. It was remarkable that in the ten years of his marriage, he had never had an argument with his wife, stating that when she became angry, he simply "let her holler," did what she wanted, or walked away while she blew off steam. All of his actions were characterized by his extreme compliance to the will of others. He was a well-motivated officer and a "good" patient. He showed little initiative or inventiveness, was confused and uncertain as to his future, and felt much insecurity regarding it. Because of his marked dependency upon others, he understandably was concerned over the ability to play the role of an adult.

It was postulated that this patient's marked dependent attitudes were a retreat from earlier hostile-aggressive feelings towards authoritarian parental figures, feelings so completely repressed that he himself was unable to recognize their existence. Instead he felt only the anxiety aroused by those feelings in the presence of people who, to him, represented authority. Thus, when working as a salesman, he had excessive perspiration and palpitations when it was necessary to talk to the boss, or to important customers, and even in the hospital he became tense and anxious when ward rounds were made by his phys-

ician in the mornings. When he lost his job as a salesman in 1950, because of his lack of the necessary aggressivity, he returned to the protection of the Army where he could find a niche for himself and feel protected and secure in his job. His need for maternal love and protection was also apparent in his statement that he felt at ease in the presence of women, and never felt excited or anxious in their presence.

As might be expected, his gastro-intestinal symptoms developed at times when his need to be taken care of was greatest. He dated the onset of his symptoms to a specific episode in the ETC in 1944 when his unit was under attack by the enemy. At that time he was pinned down for a considerable length of time, became completely incapacitated by fear and anxiety, wanting to run away, but knew he couldn't. He stated that at no time before in his life prior to the bombardment had he been aware of such intense epigastric burning, which may in one sense have been a fulfillment of his wish for care. Having once established a system for the expression of his needs, he had recurrent episodes of similar distress. The two episodes mentioned in his case summary occurred in similar psychologic situations, although the precipitating factors were not as annihilating as on the first occasion. In November 1950, when he was faced with the loss of his job, a conflict which he eventually resolved by returning to the security offered by the Army, and again in August 1951, when he was awaiting transfer overseas to a situation that carried all of the implications of the 1944 episode in his mind, he had severe exacerbations. Finally upon reaching Korea and being exposed to the threat of having again to be an aggressive infantry unit commander he again developed symptoms of such severity that evacuation to Japan was necessary. Even here his symptoms did not subside so long as the threat of return to the same situation upon his recovery existed.

In this patient, then, one saw GI symptoms developing in situations where it was necessary for him to summon repressed aggression and where instead the patient retreated to the dependent attitudes of wanting and needing to be cared for. Not all of his anxiety situations were accompanied by GI symptoms, but those situations in which anxiety was directly related to his fear of expressing aggression were so accompanied.

As a contrast to this passive-dependent patient I would like next to discuss the last case reported, the 37-year old AAA Officer. This man differed overtly in every respect from the first patient presented. Where the latter was soft-spoken and retiring, the present patient was bitingly sarcastic and self-assertive. Highly independent, a driving individual, he had risen to field grade rank during his eleven years of service.

His GI symptoms began three years ago, shortly after his second marriage and following his transfer to a combat unit. Prior to that time he had been engaged in artillery research and worked alone. "Now," he stated, "I get provoked if people don't do a job right, and then I get a belly-ache." He is married to a strong-willed woman six years his junior who "has a mind of her own" and with whom there is a "definite clash of personalities."

The dependent strivings in this individual must be inferred, short of actual demonstration in the therapeutic setting, but that they exist may be surmised from his childhood history. Although he at first de-

scribed the family setting as "the average American family," he went on to describe a situation which was devoid of any warmth or security. His father and mother were divorced when he was ten and he and his eight-year old brother went to live with the father, who, incidentally, had had severe stomach trouble all of his life. He spoke of his father as a cruel, irritable man who was a hard worker and a "stickler for detail." He was demanding in regard to his work and stingy in regard to his money, and he told the patient and his brother that if they wanted anything they would have to figure a way to get it for themselves. When the patient was fourteen, the father remarried. The step-mother was a career woman who showed little interest in a home or children, and it became the task of the patient to look after the house and to care for his younger brother. So, at a time in childhood when the patient most needed security and the knowledge of being able to depend upon someone, those needs went unfulfilled. He learned at an early age that if love, emotional support, and affection were not forthcoming, he could gain at least some measure of security by becoming what his father wanted him to be and pleasing him in that way. In that manner his dependent needs were repressed, and he adopted instead defenses and a facade of independence, self-sustenance and an ambitious desire to succeed. Unconsciously he said to himself, "If I am like that, then father will approve of me and give me the security and affection that I need." His hostility, stemming from the frustration of those needs in childhood, remained overt only as a biting, caustic sarcasm, and GI symptoms developed when anger and hostility were evoked towards someone upon whom he was dependent, i.e., his wife, or when he met with failure in a situation in which he needed to succeed, that is, when his defenses of ambition and striving for success were breached.

Some remarks on the psychiatric therapy of these patients are in order. Previous experience with ulcer patients has shown that they are likely to become involved during therapy in a conflict between their strong dependent desires and the need to renounce and reject those desires because of shame and the resulting desire to deny them. The technical problem becomes one of helping the patient to tolerate a certain amount of dependence and to gratify him in an acceptable manner compatible with his age and personality. It can be anticipated that when the patient's dependent needs are drained through acceptable channels, his needs for strong assertion of independence and for over-compensation will diminish; this, in turn, diminishes his sense of inferiority and guilt over aggressive behavior. The plan, then, will be to help the patient have life experiences which will increase his security, and improvement in the ulcer symptoms may be expected as a result of the changed defense patterns.

That there is a need for close cooperation between the internist and the psychiatrist is self-evident; it is only with such close cooperation that the patient's history as related to each consultant may be woven into a single pattern. Reference has been made to the patient's glib and characteristic history which develops after repeated tellings. Not only is that so, but the stories told to each consultant may vary considerably in the telling. In effect, the patient tries to speak in terms of what he believes the examiner wants to hear. The question "What do you want me to tell you?" is a familiar one to anyone who has ever taken a history. To illustrate this point, let me quote from a recent article which appeared in the Bulletin of the Menn-

inger Clinic.⁵ These are the chief complaints of four patients when seen by both the internist and the psychiatrist shortly after their admissions to the Winter VA Hospital:

- Pt 1: I. Stomach pains and bloating.
P. Vague fears keep stomach in knots.
- Pt 2: I. Stomach pains make him crabby at the office.
P. Unsatisfactory conditions at the office keep him tense inside.
- Pt 3: I. Ulcer, with x-ray proof of stomach trouble.
P. Unbearably shy, nervous, and worried (Ulcer was mentioned only when the patient was specifically asked about it).
- Pt 4: I. Stomach trouble.
P. Would divorce wife if it were not for the child.

Another patient who returned to the hospital because he ostensibly had a recurrence of a surgically removed goitre told the internist that surgery or medicine was necessary again, that surgery had helped a lot, that the surgeon was fine, competent, understanding fellow, and that his financial situation was OK. He told the psychiatrist that he appreciated a hospital where people realized that medicine and surgery can't cure everything, that the surgeon had lied and that very little change had been experienced from surgery, that the surgeon was rough, crude and alarming, and that he, the patient, was desperate for financial aid. Now it might be thought that he was either being deceptive or that he was not mentally competent. When, however, one considers that all situations have many aspects and that the patient may be ambivalent about them, the

communications may not be too inconsistent.

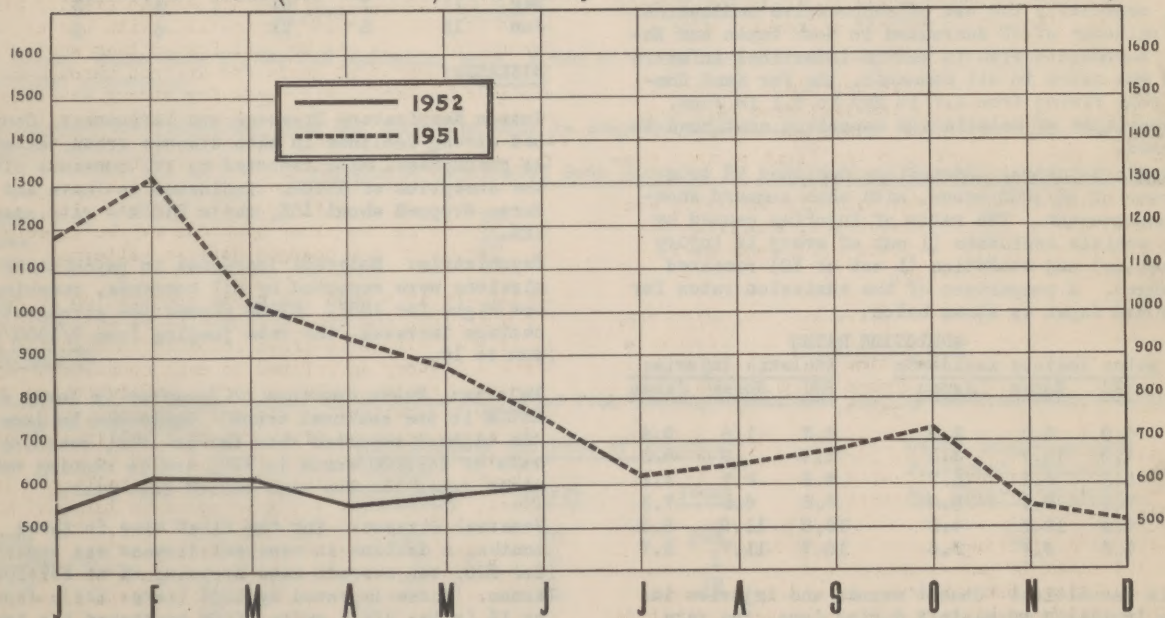
In summary, then, the patient with upper GI distress is, upon analytic investigation, invariably found to be a basically dependent individual who may present many varied outward appearances. Symptoms develop when the patient's defenses fail, and when, confronted with his own aggression, he retreats to the dependent attitude of wanting to be cared for. Therapy, to be more than palliative, must be directed at analyzing and decreasing those dependent needs, thus allowing the patient a less defensive relationship with people in real life, increasing his security and alleviating his symptoms.

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HEALTH OF ARMY TROOPS, FEC

Admission Rate(all causes). U.S. Army Personnel, Far East Command (per 1000 per year)



Admissions per 1,000 troops per annum, Army personnel, for the four-week period ending 25 June 1952 were as follows:

	FEC	JAPAN	KOREA	PHILCOM (AF)	RYCOM
All Causes	599	559	628	307	433
Diseases	449	498	431	280	393
Injuries	93	61	111	27	40
Battle Casualties	57	0	86	0	0
Psychiatric	25	17	29	18	18
Common Respiratory Diseases and Flu	66	95	54	36	61
Primary Atypical Pneumonia	2.1	1	2.7	0	1.1
Bacillary Dysentery	.22	0	.06	0	5.3
Amebiasis	.96	1.4	.83	0	0
Malaria, new	24	0	35	45	7.4
Infectious Hepatitis	5.4	6	4.8	0	14
Dermatophytosis	5.7	6.9	4.7	9	14
Rheumatic Fever	.33	.50	.28	0	0
Venereal Diseases	231	272	213	153	224

DAILY NON-EFFECTIVE RATE

All Causes	18	35	11	27	9.3
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Health of the Far East Command for the month of June 1952 refers to Army personnel only.

ADMISSION RATES:

All Causes: Aside from an increase in the battle casualty rate, no significant change occurred in the overall health of the Far East Command during June 1952. "All Causes" admissions to hospital and quarters in FEC rose 5% during the month, to an annual rate of 599 per 1000 strength. If not for a 300% rise in battle casualty rates, the FEC "All Causes" rate would have declined -- largely due to reductions in the incidence of venereal disease and respiratory infections.

Disease: Virtually no change in the total disease incidence was reported in Japan and Korea. A 40% increase was reported by RYCOM which was largely a reflection of the increase in the VD rates. It is reported this increase came about through discovery of concealed cases through an unannounced physical inspection. Psychiatric conditions increased moderately in all commands. The incidence of clinical malaria increased precipitately in Korean veterans now stationed in Japan. However, the incidence of clinical malaria remained remarkably low in Korea indicating the efficacy of malarial control measures, especially the use of suppressive medication. The incidence of VD decreased in both Japan and Korea. A moderate rise in gastro-intestinal infections was noted in all commands, the Far East Command rate rising from 1.7 in May to 5.1 in June. The incidence of malaria and hepatitis continued to decrease.

Nonbattle Injuries: Admissions declined 9% to a FEC rate of 93/1000/annum, with each command showing improvement. The ratio of injuries caused by motor vehicle accidents (1 out of every 14 injury admissions) and athletics (1 out of 10) remained unchanged. A comparison of the admission rates for Korea and Japan is shown below:

ADMISSION RATES

	Motor Vehicle Accidents			Athletic Injuries		
	FEC	Korea	Japan	FEC	Korea	Japan
Jan	6.9	9.0	2.9	2.3	1.6	3.4
Feb	7.9	10.7	3.3	2.9	.9	6.2
Mar	6.3	8.1	3.7	4.5	2.7	7.1
Apr	7.4	9.1	5.0	6.6	6.5	7.3
May	8.4	10.7	4.2	10.9	11.9	9.8
Jun	7.0	8.7	3.6	10.7	11.7	9.7

Battle Casualties: Combat wounds and injuries in Korea increased three-fold during June, the rate jumping to 86/1000/annum, the highest incidence since October 1951.

DAILY NON-EFFECTIVE RATES:

The steady decline in non-effective rates, which started last December, was halted in June when the "All Causes" rate for FEC rose 5% to 18/1000/day. In this case, again, the rise was caused by the increase in battle casualties. The following chart indicates the distribution of non-effectives (daily average number of men per 1000 not available for duty for medical reasons):

	All Causes			Battle Casualties		
	FEC	Korea	Japan	FEC	Korea	Japan
Jan	24	10	51	5	1	12
Feb	22	11	44	3	1	7
Mar	20	11	40	2	0.6	5
Apr	18	9	36	2	0.8	4
May	17	10	32	2	1.5	4
Jun	18	11	35	2	1.3	5

	Disease			Nonbattle Injuries		
	FEC	Korea	Japan	FEC	Korea	Japan
Jan	14	7	28	5	3	11
Feb	14	7	26	5	3	11
Mar	13	7	25	5	3	10
Apr	12	7	23	4	2	9
May	11	7	21	4	2	7
Jun	12	8	22	4	2	8

DISEASES:

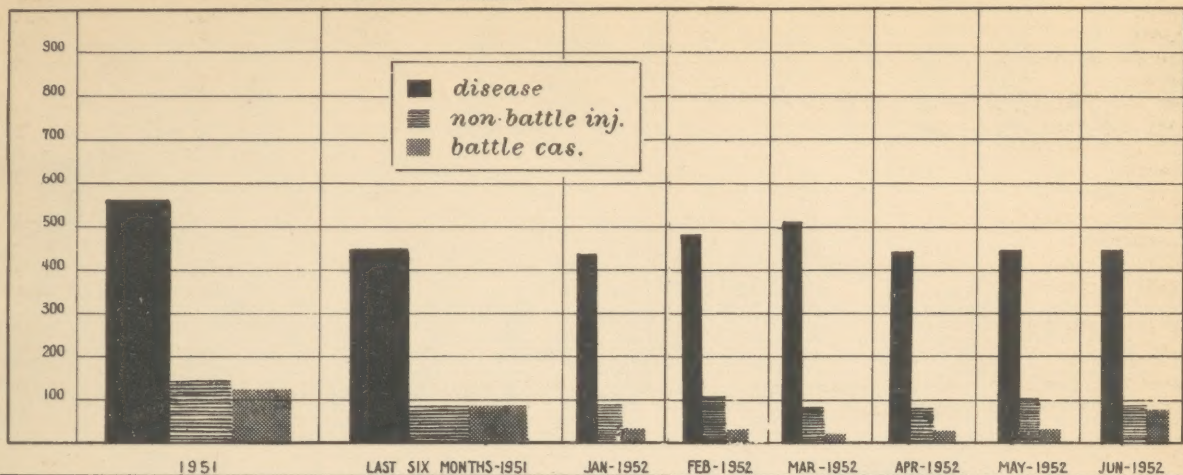
Common Respiratory Diseases and Influenza: Continued strong declines in this disease group, as well as pneumonias, were reported by all commands with the exception of RYCOM. Incidence in Japan and Korea dropped about 30%, while RYCOM's rate rose by 28%.

Psychiatric: Moderate increases in psychiatric admissions were reported by all commands, reaching new highs for 1952. RYCOM showed the strongest percentage increase, the rate jumping from 9/1000/annum to 18.

Malaria: Rates continue to increase in Korea and RYCOM in the seasonal trend. Incidence in June was the highest reported thus far in 1952, reaching a rate of 24/1000/annum in FEC, and is running well above rates for the same period last year.

Venereal Disease: For the first time in three months, a decline in venereal disease was reported for FEC, the overall rate dropping 6% to 231/1000/annum. Korea improved by 10% (rate: 221); Japan by 1% (rate: 272); while RYCOM countered the trend with an increase of 43% (rate: 224). Divisional rates for Korea and Japan are as follows:

admission rates

DISEASE, NON-BATTLE INJURY & BATTLE CASUALTY
(per 1000 per year) U.S. ARMY PERSONNEL, FEC

							Ko- rea	Japan (less XVI Corps)	May	127	263	176	129	46	132	322	502	158
							(less XVI Corps)		Jun	153	192	109	138	73	108	290	481	170
	2nd Div	3rd Div	7th Div	25th Div	40th Div	45th Div			DEATHS:									
Jan	159	132	194	183	82	73	273	454	147	Hospital and carded-for-record deaths declined in June, with a total of 81 reported for FEC. The reduction was primarily in non-battle injury deaths which dropped from 58 in May to 40 in June.								
Feb	323	159	178	166	66	65	247	431	167									
Mar	191	142	210	134	17	48	226	478	166									
Apr	97	154	187	74	45	100	260	491	153									

HOSPITALIZATION: (These data cover all patients, Army, Air Force and others.)

The bed status as of 25 June 1952 was as follows:

	Designated Beds	Operating Beds	All Patients Army Hospitals	Average Beds Occupied	
				USAF Hospitals	Navy Hospitals
Japan	13,250	10,335	3,800	96	5
Korea	5,040	4,885	2,596	7	97
PHILCOM (AF)	0	0	0	32	0
RYCOM	400	347	187	0	0
	18,690	15,567	6,583	135	102

In Korea, there were 11,700 PsW operating beds, 5,983 of which were occupied by PsW and 1,431 occupied by civilian internees.

The percent of designated beds and operating beds in Army hospitals occupied as of 25 June 1952 was as follows:

	Percent of Designated Beds Occupied	Percent of Operating Beds Occupied
Japan	29	37
Korea	52	53
RYCOM	47	54
FEC	35	41

EVACUATION:

Tabulated below is the number of patients evacuated from the major commands during the four report weeks ending 25 June 1952:

	Evacuated to the Zone of Interior			Other United Nations Personnel Evacuated to Their Homelands
	Army Personnel	Others	Total	
Japan	543	56	599	31
PHILCOM (AF)	1	0	1	-
RYCOM	16	13	29	-
FEC	560*	69	629	31

*Includes 10 Army patients hospitalized in USAF hospitals.

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